Agenda

• Introduction
  • Total Cost of Care (TCOC) Model
  • Overview of Pay-for-Performance Programs

• Rate Year 2025 Approved Program Updates
  • MHAC
  • QBR
  • RRIP/Disparity Gap
  • PAU Savings
  • Maximum Guardrail

• Digital Measures Reporting

• CY 2023 Monitoring Reports

• CRISP Reports to Track Hospital and Statewide Progress
  • Hospital Reports
  • SIHIS Reports

• Resources

• Q&A
Transitioning from the All-Payer Model to the Total Cost of Care Model

All-Payer Model (2014-2018): Hospital Focus

- Hospital savings
- Hospital quality
- Hospital alignment

Total Cost of Care Model (2019-2028): Health System Focus

- Total Cost of Care savings
- Hospital quality and population health
- System-wide provider alignment, including opportunities for primary care and other non-hospital providers
The TCOC Model requires the State of Maryland to meet the following targets:

- **TCOC Guardrail Test:** Must not exceed growth in national Medicare spending per beneficiary by more than 1% in any year and/or exceed national spending growth for two years.

- **Readmissions Reductions for Medicare:** Must match or exceed National and previous Maryland Medicare Readmission rates.

- **All-Payer Reductions in Hospital-Acquired Conditions:** Must match or exceed previous Maryland all-payer potentially preventable condition (PPC) rates.

- **Hospital Revenue under Population-Based Payment Methodology:** ≥ 95% over the course of the Model.

- **Annual Medicare TCOC Savings:** Must build up to $300 million in annual savings to Medicare by 2023.

- **All-Payer Hospital Revenue Growth Per Capita:** ≤ 3.58% per capita annually.

- **Annual Medicare TCOC Savings:** Must build up to $300 million in annual savings to Medicare by 2023.
TCOC Model Components

Population Health and Health Equity
Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid addiction, and maternal and child health.

Payment and Delivery System Reform
- Incentivization of care transformation and partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

Population-Based Revenue
- Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk
Statewide Integrated Health Improvement Strategy (SIHIS)

- SIHIS is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, address disparities, and reduce costs for Marylanders.

- CMMI approved the SIHIS goals in March 2021.

- More information on SIHIS can be found on the HSCRC website. 
  https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx
Overview of Pay-for-Performance Programs
HSCRC Performance Measurement Workgroup

- Broad stakeholder group of hospital, payer, quality measurement, academic, consumer, and government agency experts and representatives
- Meets monthly in-person and virtually (3rd Wednesday at 9:30am)
  - Meetings are public, email hsrc.quality@maryland.gov to be added to listserv
- Reviews and recommends annual updates to the performance-based payment programs
- Considers and recommends strategic direction for the overall performance measurement system
  - Align to the extent possible with National measures and strategies
  - Incorporate new measures as available such as emergency department and outpatient measures
  - Broaden focus to patient-centered population health
  - Focus on high-need patients and chronic condition management
  - Build care coordination performance measures
Guiding Principles for HSCRC Performance-Based Payment Programs

- Program must improve care for all patients, regardless of payer
- Program incentives should support achievement of TCOC model targets
- Program should prioritize measures that impact large number of patients, high cost, opportunity for improvement and areas of national focus
- Predetermined performance targets and financial impact
- Hospital ability to track progress
- Reduce disparities and advance health equity
- Encourage cooperation and sharing of best practices
- Consider all settings of care
- Programs should incentivize hospitals to improve the health of communities they serve through primary, secondary and tertiary prevention efforts
The following are HSCRC’s four main quality payment incentive programs:

- **Maryland Hospital Acquired Conditions (MHAC) Program**
  - Focuses on patient experience, patient safety, and clinical quality outcomes

- **Quality Reimbursement Program (QBR)**
  - Encourages hospitals to reduce infections and complications acquired during a hospital stay

- **Readmissions Reduction Incentive Program (RRIP)**
  - Encourages hospitals to reduce readmissions within 30 days of discharge

- **Potentially Avoidable Utilization (PAU)**
  - Focuses on improving patient care and health through reducing potentially avoidable utilization

HSCRC’s quality programs are similar to federal Medicare pay-for-performance programs, but are, wherever possible, All-Payer (instead of Medicare-only) and tailored to address MD’s unique quality improvement strategies.
RY 2025 Quality Programs
<table>
<thead>
<tr>
<th>Rate Year (Maryland Fiscal Year)</th>
<th>Calendar Year</th>
<th>Maryland Hospital Acquired Conditions (MHAC)</th>
<th>Quality Based Reimbursement (QBR)</th>
<th>Readmission Reduction Incentives Program (RRIP)</th>
<th>Rate Year Impacted by MHAC Results</th>
<th>Rate Year Impacted by QBR Results</th>
<th>Rate Year Impacted by RRIP Results</th>
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<tbody>
<tr>
<td>Q3-20</td>
<td>Q1-20</td>
<td>MHAC Base Period</td>
<td></td>
<td></td>
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<tr>
<td>Q4-20</td>
<td>Q2-20</td>
<td>MHAC Performance Period*</td>
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<tr>
<td>Q1-21</td>
<td>Q3-20</td>
<td>CMS Hospital Compare Performance Period (HCAHPS measures, All NHSN measures)**</td>
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<tr>
<td>Q2-21</td>
<td>Q4-20</td>
<td>Base Period: QBR Maryland Mortality, PSI-90, Follow-up Chronic Conditions</td>
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<tr>
<td>Q3-21</td>
<td>Q1-21</td>
<td>Performance Period: QBR Maryland Mortality, PSI-90, Follow-up Chronic Conditions</td>
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<tr>
<td>Q4-21</td>
<td>Q2-21</td>
<td>Hospital Compare THA/TKA Performance Period***</td>
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<td>Q1-22</td>
<td>Q3-22</td>
<td>RRIP Base Period#</td>
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<td></td>
</tr>
<tr>
<td>Q2-22</td>
<td>Q4-22</td>
<td>RRIP Performance Period</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3-22</td>
<td>Q1-23</td>
<td>PAU Savings Performance Period</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4-22</td>
<td>Q2-23</td>
<td>PAU Savings</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

*Two-year performance period for small hospitals
**CMS Hospital Compare Base Period (HCAHPS measures, All NHSN Measures) CY 2019 Q1-Q4
***Hospital Compare THA/TKA Complications Base Period April 1, 2015-March 31, 2018
X Indicates Data quarters CMS will not use due to COVID PHE
# RRIP Base Period for determining attainment standards. RRIP Improvement will be measured from CY 2018
RY 2025 Maryland Hospital Acquired Condition (MHAC) Program
**Purpose**

To improve patient care and hospital decision-making by adjusting GBR based on 15 identified potentially preventable complications (PPCs), *complications acquired during a hospital stay* that were not present on admission

- PPCs can lead to **poor patient outcomes**, including longer hospital stays, permanent harm, and **death**, and **increased costs**.
- **Examples of PPCs** include an accidental laceration during a procedure, improper administration of medication, hospital-acquired pneumonia

**How it Works: Revenue-at-Risk**

The program puts **2 percent** of inpatient hospital revenue at risk (maximum penalty/reward)

**Federal Alignment**

The MHAC Program is **similar to the federal Medicare HAC Reduction Program (HACRP)** but is all-payer, uses a Maryland-specific list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.
RY 2025 Data Details

• “Base” Period: July 2020-June 2022
  • Used for calculation of performance standards and normative values for case-mix adjustment
  • Used to determine hospital specific PPC exclusions
  • Used to determine small hospitals
• Performance Period: CY 2023
• 3M APR-DRG and PPC Grouper Version 40
MHAC Methodology
Overview of MHAC Methodology

### Potentially Preventable Complication Measures

- **List of 15 clinically significant PPC included in payment program.**
  - Acute Pulmonary Edema & Respiratory Failure w/ Ventilation
  - Post-Operative Infection & Deep Wound Disruption Without Procedure
  - In-Hospital Trauma & Fractures
  - Acute Pulmonary Edema & Respiratory Failure w/ Ventilation
  - Post-Operative Hemorrhage & Hematorrhea w/ Hemorrhage Control Procedure or IBD Proc
  - Septicemia & Severe Infections
  - Pulmonary Embolism
  - Accidental Puncture/Laceration During Invasive Procedure
  - Pneumonia Combo
  - Shock
  - Intravenous Pneumothorax
  - Other Complications of Obstetrical Surgical & Perineal Wounds
  - Venous Thrombosis
  - Major Femoral Infection & Other Major Obstetric Complications
  - Encephalopathy

### Global Exclusions:
- Discharges >6 PPCs
- APR-DRG SOI cells with less than 31 at-risk discharges

### Hospital PPC Exclusions:
- <20 at-risk discharges
- <2 expected PPCs

### Case-Mix Adjustment and Standardized Scores

- **Performance Measure: CY 2023**
  - Observed to Expected PPC Ratio.
  - Expected calculated by applying statewide average PPC rates by diagnosis and severity of illness level to hospitals’ patient mix (i.e., indirect standardization)
  - Attainment only score (0-100 points) calculated by comparing hospital performance to a statewide threshold and benchmark.

#### Attainment Points

<table>
<thead>
<tr>
<th>Threshold 10th Percentile</th>
<th>Benchmark 90th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

July 2020-June 2022 used to calculate statewide averages (norms) and thresholds, benchmarks.

*Small hospitals will be assessed on Cy's 22 & 23

### Hospital MHAC Score & Revenue Adjustments

- **Hospital MHAC Score is Sum of Earned Points / Possible Points with PPC Cost Weights Applied.**
- **Scores Range from 0-100**
- **Revenue neutral zone 60-70%**
- **Max Penalty -2% & Reward +2%**

<table>
<thead>
<tr>
<th>MHAC Score</th>
<th>Revenue Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>-2.00%</td>
</tr>
<tr>
<td>10%</td>
<td>-1.67%</td>
</tr>
<tr>
<td>20%</td>
<td>-1.33%</td>
</tr>
<tr>
<td>30%</td>
<td>-1.00%</td>
</tr>
<tr>
<td>40%</td>
<td>-0.67%</td>
</tr>
<tr>
<td>50%</td>
<td>-0.33%</td>
</tr>
<tr>
<td>60% to 70%</td>
<td>0.00%</td>
</tr>
<tr>
<td>80%</td>
<td>0.67%</td>
</tr>
<tr>
<td>90%</td>
<td>1.33%</td>
</tr>
<tr>
<td>100%</td>
<td>2.00%</td>
</tr>
</tbody>
</table>
Hospital performance is measured using the Observed(O) / Expected(E) ratio for each PPC.

- Lower number = better performance
- Expected number of PPCs for each hospital are calculated using the base period statewide PPC rates by APR-DRG and severity of illness (SOI).
  - See Appendix of the MHAC Final Recommendation or annual memo for details on how to calculate expected numbers.

Normative values for calculating expected numbers are included in the MHAC Summary reports on the CRS portal.
Adjustments are made to improve measurement fairness and stability.

For each hospital, discharges will be excluded if:

- The discharge has > 6 PPCs (i.e., catastrophic cases)
- The discharge is in an APR-DRG SOI group with less than 31 statewide discharges

For each hospital, PPCs will be excluded if during the base period:

- The number of discharges at-risk is less than 20
- The number of expected cases is less than 2

Two years of performance data (CY 22 & 23) are used for small hospitals (i.e., hospitals with less than 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs).

The list of hospital specific excluded PPCs is included in the MHAC Summary workbook on the CRS portal.
# RY 2025 Payment PPCs

<table>
<thead>
<tr>
<th>PPC Number</th>
<th>PPC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
</tr>
<tr>
<td>4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>9</td>
<td>Shock</td>
</tr>
<tr>
<td>16</td>
<td>Venous Thrombosis</td>
</tr>
<tr>
<td>28</td>
<td>In-Hospital Trauma and Fractures</td>
</tr>
<tr>
<td>35</td>
<td>Septicemia &amp; Severe Infections</td>
</tr>
<tr>
<td>37</td>
<td>Post-Operative Infection &amp; Deep Wound Disruption without Procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPC Number</th>
<th>PPC Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>Post-Operative Hemorrhage &amp; Hematoma w/ Hemorrhage Control Procedure or I&amp;D</td>
</tr>
<tr>
<td>42</td>
<td>Accidental Puncture/Laceration During Invasive Procedure</td>
</tr>
<tr>
<td>47</td>
<td>Encephalopathy NEW RY2025</td>
</tr>
<tr>
<td>49</td>
<td>Iatrogenic Pneumothorax</td>
</tr>
<tr>
<td>60</td>
<td>Major Puerperal Infection and Other Major Obstetric Complications</td>
</tr>
<tr>
<td>61</td>
<td>Other Complications of Obstetrical Surgical &amp; Perineal Wounds</td>
</tr>
<tr>
<td>67</td>
<td>Pneumonia Combo (with and without Aspiration)</td>
</tr>
</tbody>
</table>

Data on each payment PPC is included in the MHAC Summary Report on the CRS Portal.
RY 2025 uses FY2021 and FY2022 (post COVID) to determine performance standards for each PPC.

A threshold and benchmark value for each PPC/PPC combo are calculated based upon the base period data:

- Used to convert O/E ratio for each PPC to points (0-100)
- Threshold = 10th percentile
- Benchmark = 90th percentile

Monitoring reports provide performance results for all PPCs.

Thresholds and Benchmarks for each payment PPC are included in the MHAC Summary Report on the CRS Portal.
MHAC Score: Attainment Score

PPC 9 Shock – Attainment Score

Threshold
(Base Year 10th Percentile)
O/E = 1.7988

Benchmark
(Base Year 90th Percentile)
O/E = 0.4235

Hospital O/E ratio = 0.90
Calculated to an attainment score of 65
3M Cost-Based Weights: Proxy for Harm

The cost estimates are the relative incremental cost increase for each PPC, which can be a proxy for the harm of the PPC within the hospital stay.

<table>
<thead>
<tr>
<th>Hypothetical Example with Three PPCs: Weights Applied to Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPC</td>
</tr>
<tr>
<td>-----</td>
</tr>
<tr>
<td><strong>Hospital A</strong></td>
</tr>
<tr>
<td>Worse on Higher Weighted PPCs</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td><strong>Hospital B</strong></td>
</tr>
<tr>
<td>Worse on Lower Weighted PPCs</td>
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<td></td>
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</tr>
</tbody>
</table>

Version 40 PPC Cost Weights are included in the MHAC Summary Report on the CRS Portal.
## RY 2025 Payment PPCs Cost Weights

<table>
<thead>
<tr>
<th>PPC Number</th>
<th>PPC Description</th>
<th>3M v40 PPC Cost Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Acute Pulmonary Edema and Respiratory Failure without Ventilation</td>
<td>0.5005</td>
</tr>
<tr>
<td>4</td>
<td>Acute Pulmonary Edema and Respiratory Failure with Ventilation</td>
<td>1.5519</td>
</tr>
<tr>
<td>7</td>
<td>Pulmonary Embolism</td>
<td>1.1248</td>
</tr>
<tr>
<td>9</td>
<td>Shock</td>
<td>1.0478</td>
</tr>
<tr>
<td>16</td>
<td>Venous Thrombosis</td>
<td>1.5503</td>
</tr>
<tr>
<td>28</td>
<td>In-Hospital Trauma and Fractures</td>
<td>0.3379</td>
</tr>
<tr>
<td>35</td>
<td>Septicemia &amp; Severe Infections</td>
<td>1.4394</td>
</tr>
<tr>
<td>37</td>
<td>Post-Operative Infection &amp; Deep Wound Disruption without Procedure</td>
<td>1.5936</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>PPC Number</th>
<th>PPC Description</th>
<th>3M v40 PPC Cost Weight</th>
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</thead>
<tbody>
<tr>
<td>41</td>
<td>Post-Operative Hemorrhage &amp; Hematoma w/ Hemorrhage Control Procedure or I&amp;D</td>
<td>0.9745</td>
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<tr>
<td>42</td>
<td>Accidental Puncture/Laceration During Invasive Procedure</td>
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<td>49</td>
<td>Iatrogenic Pneumothorax</td>
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<td>61</td>
<td>Other Complications of Obstetrical Surgical &amp; Perineal Wounds</td>
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<tr>
<td>67</td>
<td>Pneumonia Combo (with and without Aspiration)</td>
<td>1.1332</td>
</tr>
</tbody>
</table>
Score & Revenue Adjustment Scale

- The final score is calculated across all PPCs included for each hospital.
  - Sum numerator and denominator points to get percent score
- Scores and revenue adjustment scale range from 0% to 100%; scale has hold harmless zone between 60% and 70%.
  - Hold harmless zone determined from average/median score modeling
- Maximum penalty and reward is 2% of inpatient revenue.

<table>
<thead>
<tr>
<th>Final MHAC Score</th>
<th>Revenue Adjustment</th>
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<tbody>
<tr>
<td>0%</td>
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<tr>
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<td>-1.83%</td>
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<td>25%</td>
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</tr>
<tr>
<td><strong>100%</strong></td>
<td><strong>2.00%</strong></td>
</tr>
</tbody>
</table>

The MHAC Summary report on the CRS portal provides PPC specific points, Hospital MHAC Scores, calculation sheet, and revenue adjustment scale.
• Evaluate hospital performance on PPCs
  • 15 included in payment program, others in monitoring for potential inclusion in future years
• Assess hospital performance on attainment from 0-100% with a revenue hold harmless zone between 60-70%
• Weight PPCs in payment program by 3M cost weights as a proxy for patient harm
• Maximum reward and penalty at 2%
Hospitals are exceeding the TCOC model goal to not backslide on PPC reductions gained under the All-Payer model.

Note: Based on V39 final data through December 2022
Quality Based Reimbursement (QBR) Program

**Purpose**
To incentivize quality improvement across three patient-centered quality measurement domains:

1. **Person and Community Engagement (HCAHPS)** - 8 survey-based measures + follow-up
2. **Clinical Care** - inpatient mortality rate + hip/knee replacement complication rate

**How it Works: Revenue-at-Risk**
The Program puts 2 percent of inpatient hospital revenue at risk (maximum penalty/reward)

**Federal Alignment**
The QBR program uses similar measures to the federal Medicare Value-Based Purchasing (VBP) program but has an all-payer focus and can adjust domain weights to focus on MD-specific improvements.

![VBP and QBR Weight Domains](chart)

- **VBP Weight Domains**
  - Efficiency 25%
  - Safety 25%
  - Clinical Care 25%
  - Person and Community Engagement 25%

- **QBR Weight Domains**
  - Safety 35%
  - Clinical Care 15%
  - Person and Community Engagement 50%
Overview of QBR Methodology

### Performance measures

- **Person and Community Engagement (PCE)**: follow-up after chronic conditions exacerbation measure (TFU) Medicare, NEW add TFU Medicaid; 8 HCAHPS categories top box, 4 HCAHPS categories linear score.
- **Safety**: (6 measures: 5 CDC NHSN HAI categories; all-payer PSI 90 measure)
- **Clinical Care**: (inpatient mortality, THA/TKA complications)

### Standardized measure scores

- **Individual measures are converted to 0–10 points:**
  - Points for attainment are based on performance versus a national threshold (median) and benchmark (top 5%)
  - Points for improvement are based on performance versus base (historical perf.) and benchmark

### Hospital QBR score and revenue adjustments

- Hospital QBR score is the sum of earned points / possible points with domain weights applied
  - Scale of 0–80%
  - Max penalty -2% & reward +2%

### PCE DOMAIN

- **Clinical Care**: 15%
- **Person & Community Engagement**: 50%
- **Consistency**: 20%
- **Linear**: 20%
- **Top Box**: 50%
- **TFU**: 10%

## Abbreviated Preset Scale

<table>
<thead>
<tr>
<th>Preset Scale</th>
<th>QBR Score</th>
<th>Financial Adjustment</th>
</tr>
</thead>
<tbody>
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<td>Max Penalty</td>
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<tr>
<td>10%</td>
<td>-1.51%</td>
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<td>20%</td>
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<td>30%</td>
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<td>Penalty/Reward Cutpoint</td>
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<td>50%</td>
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<td>60%</td>
<td>0.57%</td>
<td></td>
</tr>
<tr>
<td>70%</td>
<td>1.45%</td>
<td></td>
</tr>
<tr>
<td>Max Reward</td>
<td>80%+</td>
<td>2.00%</td>
</tr>
</tbody>
</table>
QBR Methodology: Measure Inclusion Rules and Data Sources

- HSCRC will use the data submitted to CMS for the Inpatient Quality Reporting program for calculating hospital performance scores for all measures with exception of PSI-90 and the mortality measures, which are calculated using HSCRC case-mix data. The TFU measure is calculated using CCLF data.

- Hospitals must have at least 100 HCAHPS survey/HCAHPS results to be included in the program.

- For hospitals with measures that have no base period data, attainment only scores will be used to evaluate performance.

- Domain weighting is adjusted based on data availability (ie., if no safety score, PCE domain weighted at 77% and Clinical Care domain weighted at 23%)

*It is imperative that hospitals review the data in the Care Compare Preview Reports as soon as it is available from CMS.*
QBR Methodology: Measure Inclusion Rules and Data Sources

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>Clinical Care</th>
<th>Person and Community Engagement*</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inclusion Criteria</strong></td>
<td>Mortality: <strong>No minimum threshold</strong> for hospitals</td>
<td>- At least <strong>100 surveys</strong> during performance period</td>
<td>- At least <strong>three measures</strong> needed to calculate hospital score</td>
</tr>
<tr>
<td></td>
<td>- Statewide: <strong>20 cases for APR-DRG cell</strong> to be included</td>
<td></td>
<td>- Each NHSN measure requires at least <strong>one predicted infection</strong> during the applicable period</td>
</tr>
<tr>
<td></td>
<td>THA/TKA: 25 cases for hospitals^</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data Source</strong></td>
<td>Mortality: HSCRC <strong>Case-Mix Data</strong></td>
<td>HCAHPS surveys reported to CMS Hospital Compare</td>
<td>CDC- NHSN data reported to CMS Hospital Compare</td>
</tr>
<tr>
<td></td>
<td>THA/TKA: CMS Hospital Compare</td>
<td>TFU: CCLF</td>
<td>PSI-90: HSCRC Case-Mix</td>
</tr>
</tbody>
</table>

*Must have PCE domain score to be included in QBR Program

^Maryland: Hospital with less than 50 elective procedures over three years that are in the top 10th percentile of complexity as defined by average case mix index
RY 2025 Maryland Mortality Measure

- Maryland measures **inpatient** mortality, risk-adjusted for:
  - 3M risk of mortality (ROM)
  - Sex, age, and age-squared
  - Transfers from another acute hospital within MD
  - Palliative Care status
  - Confirmed COVID-19 flag

- Measure inclusion/exclusion criteria provided in calculation sheet.
  - Subset of APR-DRGs account for 80% of all mortalities.
  - Specific high mortality APR-DRGs and very low mortality APR-DRGs are removed.

- All-Payer
- Hospitals evaluated using **risk-adjusted survival rate**

Case- and Hospital-level reports provided on CRS portal monthly.
RY 2025 Timely Follow-up After Acute Exacerbations of Chronic Conditions

• NQF endorsed health plan measure that looks at percentage of ED, observation stays, and inpatient admissions for one of the following six conditions, where a follow-up was received within time frame recommended by clinical practice:
  • Hypertension (7 days)
  • Asthma (14 days)
  • Heart Failure (14 days)
  • CAD (14 days)
  • COPD (30 days)
  • Diabetes (30 days)

• COVID pts included
• Medicaid and Medicare FFS measured separately

Summary reports are posted to the CRS portal monthly. Case-Level reports are posted for Medicare only.
PSI-90 is a composite measure of 10 AHRQ-specified PSIs of in-hospital complications and adverse events following surgeries, procedures, and childbirth:

- PSI 03 Pressure Ulcer
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 08 In-Hospital Fall with Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Abdominopelvic Accidental Puncture or Laceration Rate

Case- and Hospital-level reports are posted to the CRS portal monthly.
QBR Scoring: Better of Attainment or Improvement

### Attainment

- compares hospital’s rate to a threshold and benchmark.
- if a hospital’s score is equal to or greater than the benchmark, the hospital will receive 10 points for achievement.
- if a hospital’s score is equal to or greater than the achievement threshold (but below the benchmark), the hospital will receive a score of 1–9 based on a linear scale established for the achievement range.

### Improvement

- compares hospital’s rate to the base year (the highest rate in the previous year for opportunity and HCAHPS performance scores)
- if a hospital’s score on the measure during the performance period is greater than its baseline period score but below the benchmark (within the improvement range), the hospital will receive a score of 0–9 based on the linear scale that defines the improvement range.
HCAHPS Performance: MD Compared to the Nation, Top-Box Scores, CY 2019 vs 7/1/21-6/30/22

HCAHPS Measure Results: Maryland Compared to Nation

<table>
<thead>
<tr>
<th>Measure</th>
<th>MD Base</th>
<th>MD Performance</th>
<th>Nation Base</th>
<th>Nation Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Communication</td>
<td>76</td>
<td>74</td>
<td>81</td>
<td>79</td>
</tr>
<tr>
<td>Dr Communication</td>
<td>77</td>
<td>76</td>
<td>82</td>
<td>80</td>
</tr>
<tr>
<td>Staff Responsiveness</td>
<td>61</td>
<td>56</td>
<td>70</td>
<td>66</td>
</tr>
<tr>
<td>Medication Explained</td>
<td>61</td>
<td>57</td>
<td>65</td>
<td>62</td>
</tr>
<tr>
<td>Discharge Info Provided</td>
<td>85</td>
<td>85</td>
<td>87</td>
<td>86</td>
</tr>
<tr>
<td>Understood Post-Discharge Care</td>
<td>49</td>
<td>47</td>
<td>54</td>
<td>51</td>
</tr>
<tr>
<td>Clean &amp; Quiet</td>
<td>53.5</td>
<td>61</td>
<td>69</td>
<td>67</td>
</tr>
<tr>
<td>9/10 Overall Rating</td>
<td>66</td>
<td>64</td>
<td>73</td>
<td>71</td>
</tr>
</tbody>
</table>
• In RY 2024, HCAHPS linear measure results were added to further incentivize focus on HCAHPS by providing credit for improvements along the continuum and not just improvements in top-box scores
• 20% of PCE domain (10% of overall QBR score)
• 4 measures chosen are correlated with other patient safety outcomes
Medicaid TFU

- Beginning in RY 2025, Medicaid TFU rates were added to the QBR as 5% of the PCE domain (2.5% of overall QBR score)
- Added due to disparities between payers (Medicaid and Medicare)
NHSN SIR Values for CY19 Compared CY2021Q3- CY2022Q2, Maryland vs. the Nation.
Maryland Statewide All-Payer Performance on PSI-90 and Component Indicators, CY 2022 Compared to FY 2021 (July 2020-June 2021)
Hospital Level Performance, Mortality Measure

Risk-Adjusted Survival Rate - CY22

Survival Rate (Percentage)

Maryland Hospitals

CY22 Performance
THA/TKA

Data Source: Care Compare
Data Time Period: 4/1/18-3/31/2021

Rate with Complications (%)

2.27
2.16

THA/TKA by-hospital performance
Data Time Period: 4/1/18-3/31/2021
Overall Score & Revenue Adjustment Scale

1. Assess performance on each measure in the domain
2. Standardize measure scores relative to performance standards
3. Calculate the total points a hospital earned divided by the total possible points for each domain
4. Finalize the total hospital QBR score (0 to 100 percent) by weighting the domains based on the overall percentage placed on each domain
5. Convert the total hospital QBR score into a revenue adjustment using the preset scale

<table>
<thead>
<tr>
<th>Abbreviated Pre-Set Scale</th>
<th>QBR Score</th>
<th>Financial Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max Penalty</td>
<td>0%</td>
<td>-2.00%</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>-1.51%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>-1.02%</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>-0.54%</td>
</tr>
<tr>
<td>Penalty/Reward Cutpoint</td>
<td>41%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>0.46%</td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>0.97%</td>
</tr>
<tr>
<td></td>
<td>70%</td>
<td>1.49%</td>
</tr>
<tr>
<td>Max Reward</td>
<td>80%+</td>
<td>2.00%</td>
</tr>
</tbody>
</table>
RY 2025 Measurement Methodology Recap

- Measures are converted to 0-10 points using performance standards
- Final score is the better of attainment or improvement
- QBR Score: Sum of earned points/possible points with domain weights
- Preset Scale of 0-80%, with 41% cutpoint
- Max penalty and reward at 2%

- PCE Domain (50%)
  - HCAHPS top-box
  - HCAHPS linear
  - TFU- Medicare FFS
  - TFU- Medicaid *NEW in RY 2025*

- Safety Domain (35%)
  - PSI-90
  - 6 NHSN HAI measures

- Clinical Care Domain (15%)
  - IP Mortality
  - THA/TKA
RRIP Methodology
RRIP and RRIP-Disparity Gap Methodology Overview

### 30-day, All-Cause Readmission Measure
- **Measure Includes:**
  - Readmissions within 30 days of Acute Case Discharge:
    - All-Payer
    - All-Cause
    - All-Hospital (both intra- and inter-hospital)
    - Chronic Beds included
    - IP-Psych and Specialty Hospitals included
    - Adult oncology Discharges included
- **Global Exclusions:**
  - Planned Admissions
  - Same-day and Next-day Transfers
  - Rehab Hospitals
  - Discharges leaving Against Medical Advice Deaths

### Case-Mix Adjustment
- **Performance Measure:** CY 2023 Case-mix Adjusted Readmission Rate, adjusted for out-of-state readmissions (Attainment);
  - Reduction in Case-mix Adjusted Readmission Rate from CY2018 Base Period (Improvement).
- **Case-mix Adjustment:**
  - Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).
  - \[\text{Observed Unplanned Readmissions} / \text{Expected Unplanned Readmissions} \times \text{Statewide Readmission Rate}\]

### Revenue Adjustments
- **Hospital RRIP revenue adjustments are based on the better of attainment or improvement, scaled between the Max Reward and Max Penalty.**
- **Scores Range from Max Penalty -2% & Reward+2%**

<table>
<thead>
<tr>
<th>All Payer Readmission Rate Change CY18-23</th>
<th>% IP Revenue Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving</td>
<td>A</td>
</tr>
<tr>
<td>-28.50%</td>
<td>2.00%</td>
</tr>
<tr>
<td>-23.25%</td>
<td>1.50%</td>
</tr>
<tr>
<td>-18.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>-12.75%</td>
<td>0.50%</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td><strong>-7.50%</strong></td>
</tr>
<tr>
<td><strong>Improvement</strong></td>
<td><strong>0.00%</strong></td>
</tr>
<tr>
<td><strong>-2.25%</strong></td>
<td><strong>-0.50%</strong></td>
</tr>
<tr>
<td><strong>3.00%</strong></td>
<td><strong>-1.00%</strong></td>
</tr>
<tr>
<td><strong>8.25%</strong></td>
<td><strong>-1.50%</strong></td>
</tr>
<tr>
<td><strong>13.50%</strong></td>
<td><strong>-2.00%</strong></td>
</tr>
<tr>
<td><strong>Worsening</strong></td>
<td><strong>-2.00%</strong></td>
</tr>
</tbody>
</table>

**Attainment**
Readmissions Reduction Incentive Program (RRIP)

**Purpose**
To incentivize hospitals to reduce avoidable readmissions by linking payment to (1) improvements in readmissions rates, and (2) attainment of relatively low readmission rates.

- **What is a readmission?** A readmission occurs when a patient is discharged from a hospital and is subsequently re-admitted to any hospital within 30 days of the discharge.
- **Why focus on readmissions?** Preventable hospitals readmissions may result from complications from previous hospitalizations or inadequate care coordination following discharge and can lead to substandard care quality for patients and unnecessary costs.

**How it Works: Revenue-at-Risk**
The program puts 2 percent of inpatient hospital revenue at risk (maximum penalty/reward) + 0.5 percent max disparity gap reward

**Federal Alignment**
The RRIP is similar to the Medicare Hospital Readmissions Reduction Program (HRRP), but has an all-payer focus.
Performance Metric

- Case-Mix Adjusted Inpatient Readmission Rate
  - 30-Day
  - All-Cause, All-Payer
  - All-Hospital (both intra- and inter- hospital)
  - Chronic beds and readmissions to specialty hospitals included
- Exclusions:
  - Same-day and next-day transfers
  - Rehabilitation Hospitals
  - Pediatric Oncology discharges
  - Planned readmissions – CMS Planned Readmission Logic (v4 2022), rehab and OB deliveries
  - Deaths, Left AMA
- Adjustments
  - APR-DRG SOI

Summary and case-level* reports are posted to the CRS portal monthly.

*Patients who opt-out of CRISP data-sharing and/or experience SUD are excluded from patient-level reports
Data Sources and Timeframe

- Inpatient abstract/case mix data with CRISP Unique Identifier (EID).
  - Base period: CY 2018 (using CY21 norms)
  - Normative period: CY 2021 (post COVID)
  - Performance period: CY 2023
  - v40 of the APR grouper
- Data on out of state readmissions is obtained from Medicare and used to adjust the all-payer readmission rate
- Looks 30-days after the performance period

Example CY 2023

<table>
<thead>
<tr>
<th>Discharge Date</th>
<th>+ 30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, 2023 – December 31, 2023</td>
<td>January 30, 2023</td>
</tr>
</tbody>
</table>

December’s Readmissions
Case-Mix Adjustment

- Hospital performance is measured using the Observed (O) unplanned readmissions / Expected (E) unplanned readmission ratio and multiplying by the statewide base period readmission rate.

- Expected number of unplanned readmissions for each hospital are calculated using the discharge APR-DRG and severity of illness (SOI).
Measuring the Better of Attainment or Improvement

- The RRIP continues to measure the better of attainment or improvement due to concerns that hospitals with low readmission rates may have less opportunity for improvement.
- RRIP adjustments are scaled, with maximum penalties up to 2% of inpatient revenue and maximum rewards up to 2% of inpatient revenue.

<table>
<thead>
<tr>
<th>Rate Year</th>
<th>Performance Year</th>
<th>Improvement Target (from CY 2018)</th>
<th>Attainment Reward Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>RY 2025</td>
<td>CY 2023</td>
<td>7.50%</td>
<td>11.32%*</td>
</tr>
</tbody>
</table>

Attainment threshold is 65th percentile of readmission rate in 2018, further adjusted for out-of-state readmissions.
Improvement Scaling

- Improvement compares CY23 case-mix adjusted inpatient readmission rates to CY18 case-mix adjusted inpatient readmission rates.
- Improvement Target for CY23 = 7.50% cumulative decrease.
- Adjustments range from 2% reward to 2% penalty, scaled for performance.

<table>
<thead>
<tr>
<th>All Payer Readmission Rate Change CY18-23</th>
<th>RRIP % Inpatient Revenue Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Readmission Rate</td>
<td>B</td>
</tr>
<tr>
<td>-28.50%</td>
<td>2.00%</td>
</tr>
<tr>
<td>-23.25%</td>
<td>1.50%</td>
</tr>
<tr>
<td>-18.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>-12.75%</td>
<td>0.50%</td>
</tr>
<tr>
<td>-7.50%</td>
<td>0.00%</td>
</tr>
<tr>
<td>-2.25%</td>
<td>-0.50%</td>
</tr>
<tr>
<td>3.00%</td>
<td>-1.00%</td>
</tr>
<tr>
<td>8.25%</td>
<td>-1.50%</td>
</tr>
<tr>
<td>13.50%</td>
<td>-2.00%</td>
</tr>
<tr>
<td>Worsening Readmission Rate</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Attainment Scaling

- Attainment scaling compares CY23 case-mix adjusted inpatient readmission rates to a state threshold (65th percentile of 2018 readmission rates)
  - Attainment scores adjusted to account for readmissions occurring at non-Maryland hospitals (OOS adjustment)
- Attainment Benchmark for CY23= 11.32%
- Adjustments range from 2% reward to 2% penalty, scaled for performance

<table>
<thead>
<tr>
<th>All Payer Readmission Rate CY23</th>
<th>RRIP % Inpatient Revenue Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOWER</td>
<td></td>
</tr>
<tr>
<td>8.15%</td>
<td>2.0%</td>
</tr>
<tr>
<td>8.47%</td>
<td>1.80%</td>
</tr>
<tr>
<td>8.79%</td>
<td>1.60%</td>
</tr>
<tr>
<td>9.10%</td>
<td>1.40%</td>
</tr>
<tr>
<td>9.42%</td>
<td>1.20%</td>
</tr>
<tr>
<td>9.74%</td>
<td>1.00%</td>
</tr>
<tr>
<td>10.05%</td>
<td>0.80%</td>
</tr>
<tr>
<td>10.37%</td>
<td>0.60%</td>
</tr>
<tr>
<td>10.69%</td>
<td>0.40%</td>
</tr>
<tr>
<td>11.00%</td>
<td>0.20%</td>
</tr>
<tr>
<td>11.32%</td>
<td>0.00%</td>
</tr>
<tr>
<td>11.64%</td>
<td>-0.20%</td>
</tr>
<tr>
<td>11.95%</td>
<td>-0.40%</td>
</tr>
<tr>
<td>12.27%</td>
<td>-0.60%</td>
</tr>
<tr>
<td>12.59%</td>
<td>-0.80%</td>
</tr>
<tr>
<td>12.90%</td>
<td>-1.00%</td>
</tr>
<tr>
<td>13.22%</td>
<td>-1.20%</td>
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<td>13.54%</td>
<td>-1.40%</td>
</tr>
<tr>
<td>13.85%</td>
<td>-1.60%</td>
</tr>
<tr>
<td>14.17%</td>
<td>-1.80%</td>
</tr>
<tr>
<td>14.49%</td>
<td>-2.00%</td>
</tr>
</tbody>
</table>
RY 2025 Measurement Methodology Recap

- Performance Metric: Case-mix adjusted readmission rates
- Case-mix adjustment:
  - Observed Unplanned Readmissions / Expected Unplanned Readmissions * Statewide Readmission Rate
- Readmissions targets: Better of improvement or attainment
  - Improvement – 7.50% Improvement target; max 2% reward at 28.50% improvement
  - Attainment – 11.32% Attainment target; max 2% reward at 8.15% rate
State on track to meet goal of 7.50% improvement in readmissions compared to CY 2018.
RRIP-Disparity Gap Methodology
The Readmissions Reduction Incentive Program includes a within-hospital disparities readmissions measure, making it the only statewide program in the nation with an incentive for reducing disparities in all-payer readmission rates.

HSCRC rewards hospitals with reductions in year-over-year overall readmission rate disparities related to race and socioeconomic status, with the goal of a 50% reduction in disparities over 8 years.

Rewards are scaled:
- Rewards are based on performance in 2018
- Rewards begin at 0.25% IP revenue for hospitals on track for 50% reduction in the disparity gap measure over 8 years.
- Rewards are capped at 0.50% of IP revenue for hospitals on pace for a 75% or larger reduction in the disparity gap measure over 8 years.
Patient Adversity Index (PAI) Measurement

- HSCRC-developed claims-based measure
- Calculated for each discharge based on social factors:
  - Medicaid status (Yes or No)
  - Race (Black or Non-Black)
  - Area Deprivation Index (ADI), measure of neighborhood disadvantage
- Social factors weighted to reflect the strength of its association with readmissions
- Larger value = higher adversity
- PAI value is normalized so that statewide mean is 0. Each 1-point change in the scale represents a change of one standard deviation.
Performance Metric - Readmissions Disparity Gap Improvement

Disparity gap: reflection of how readmission risk within a hospital changes for patients with varying levels of PAI

- Estimates the change in readmission rates per one-unit change in PAI at each hospital
- Adjustments made based on:
  - Age
  - APR-DRG
  - Gender
  - Mean PAI value at the hospital (to avoid penalizing hospitals that serve higher proportions of high PAI/highly disadvantaged patients)

Hospital payments are based on the percent change of the disparity gap between the base period (2018) and performance period (2023).
RY 2025 Readmissions Disparity Gap Scaling

- Assesses improvement only
- Model Goal: At least 50% of hospitals reduce their disparities in readmissions by 50% by RY2029
- CY 2023 performance standards: -29.29% threshold to begin rewards, -50% for full reward
- Reward-only
- Rewards scaled up to .50% of IP revenue
RY 2025 Measurement Methodology Recap

- Performance metric: % change in disparity gap comparing CY 2023 to CY 2018
- Begin receiving rewards at 29.29% reduction in readmission disparities compared to CY 2018
Readmissions Disparity Gap Improvement, CY 2022 compared to CY 2018

- Hospital Disparity Gap Improvement
RY 2024 Potentially Avoidable Utilization (PAU) Savings Policy
Purpose

• To encourage hospitals to focus on improved care coordination and enhanced community-based care by holding hospitals accountable for potentially avoidable utilization

• Designed to encourage hospitals to look at upstream, community-based factors that influence utilization

How it Works

“Potentially avoidable utilization” is defined as hospital care that is unplanned and may be prevented through improved care quality, care coordination, or effective community-based care

Methodology

The HSCRC examines the following measures in its PAU calculations:

• **30-day readmissions (uses similar logic as RRIP)** – All Hospital All Cause 30-Day Readmissions with adjustment for planned admissions

• **Avoidable admissions** – Ambulatory-care sensitive conditions identified with AHRQ Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs) (e.g. admissions for diabetes complications, admissions for urinary tract infections)
Purpose of PAU Savings and Overview

• PAU Savings Concept
  • The Global Budget Revenue (GBR) system assumes that hospitals will be able to reduce their PAU as care transforms in the state
  • The PAU Savings Policy prospectively reduces hospital GBRs in anticipation of those reductions

• Mechanism
  • Statewide reduction is scaled for each hospital based on avoidable admission rates and readmission revenue linked to the hospital in a prior year
## Per Capita Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs)

**Measure definition:** AHRQ Prevention Quality Indicators, which measure adult (18+) ambulatory care sensitive conditions. AHRQ Pediatric Quality Indicators focuses on preventable hospitalizations among pediatric patients.

**Data source:** Inpatient and observation stays >= 24 hours.

## Revenue from PAU Readmissions

**Measure definition:** 30-day unplanned readmissions measured at the sending hospital.

**See next slide for methodology.**

**Data Source:** Inpatient and observation stays >= 24 hours.
RY2024 PAU Readmissions

- For RY2024 staff plans to maintain the readmission measure used under the RY2020 PAU Savings Policy
  - PAU Readmissions revenue are associated with the sending hospital, rather than the receiving hospital
  - To calculate the readmissions revenue associated with the sending hospital:
    - Calculated the average cost of an intra-hospital readmission (to and from the same hospital)
    - Apply the average cost to the total number of sending discharges from that hospital which resulted in non-PQI readmission
PAU reduction: Express as incremental

- Starting in RY2020, changed how PAU reduction is expressed in the update factor
  - Previously reversed out previous year’s PAU reduction and implemented current year PAU reduction
  - Starting in RY20, calculating and displaying the incremental change only

- Use the inflation and population adjustments of the update factor to determine the statewide PAU reduction (i.e., do not provide inflation or population adjustments on PAU revenue)
Statewide PAU Savings Calculation

Table 1. Calculation of Statewide PAU Reduction

<table>
<thead>
<tr>
<th>Calculation of Statewide Reduction</th>
<th>Formulas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Permanent Revenue in Previous Rate Year</td>
<td>A</td>
</tr>
<tr>
<td>Inflation Factor + Volume Adj. for Upcoming Rate Year</td>
<td>B</td>
</tr>
<tr>
<td>Total Experienced PAU $ in Previous Performance Year (CY)</td>
<td>C</td>
</tr>
<tr>
<td>Required Revenue Reduction $</td>
<td>D = B*C</td>
</tr>
<tr>
<td>Required Revenue Reduction %</td>
<td>E = D/A</td>
</tr>
<tr>
<td>Adjusted Rounded Statewide Revenue Reduction Value %</td>
<td>F = Round(E,4)</td>
</tr>
<tr>
<td>Adjusted Required Revenue Reduction $</td>
<td>G = F*A</td>
</tr>
<tr>
<td>Total PAU %</td>
<td>H</td>
</tr>
<tr>
<td>Total PAU $</td>
<td>I = A*H</td>
</tr>
<tr>
<td>Required Percent Reduction PAU</td>
<td>J = G/I</td>
</tr>
</tbody>
</table>

Table 2. Calculation of PAU Savings Domain Weights

<table>
<thead>
<tr>
<th>PAU Savings Domains</th>
<th>PAU Revenue</th>
<th>PAU Domain Weights (%)</th>
<th>PAU Reduction (%)</th>
<th>PAU Reduction ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidable Admissions</td>
<td>K</td>
<td>M = K/C</td>
<td>O = M*F</td>
<td>Q = M * G</td>
</tr>
<tr>
<td>Non-PQI Readmissions</td>
<td>L</td>
<td>N = L/C</td>
<td>P = N*F</td>
<td>R = N * G</td>
</tr>
<tr>
<td>Total Experienced PAU $</td>
<td>K + L = C</td>
<td>M + N = 100%</td>
<td>O + P = F</td>
<td>Q + R = G</td>
</tr>
</tbody>
</table>
# Hospital-Specific PAU Savings

<table>
<thead>
<tr>
<th>VALUES</th>
<th>FORMULAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hosp ID</td>
<td>A</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>B</td>
</tr>
<tr>
<td>Permanent Total Revenue</td>
<td>C</td>
</tr>
<tr>
<td>Avoidable Admissions Performance</td>
<td>D</td>
</tr>
<tr>
<td>Avoidable Admissions Reduction</td>
<td>( E = \frac{D}{\text{Statewide Total}} \times \text{Adjusted proposed required revenue reduction} \times \text{Avoidable Admissions (PQIs and PDIs) Domain Weight (M in previous slide)} )</td>
</tr>
<tr>
<td>Avoidable Admission Adjustment $</td>
<td>( F = E \times C )</td>
</tr>
<tr>
<td>Avoidable Admissions Adjustment $(Normalized)</td>
<td>( G = \frac{F \times \text{(Adjusted proposed required revenue reduction) \times \text{Avoidable Admissions (PQIs and PDIs) Domain Weight (M in previous slide)}}}{\text{Statewide Total F}} )</td>
</tr>
<tr>
<td>CY22 Readmissions %</td>
<td>H</td>
</tr>
<tr>
<td>PAU Readmissions Adjustment %</td>
<td>( I = \frac{H}{\text{Statewide Total}} \times \text{Adjusted proposed required revenue reduction} \times \text{Readmissions Domain Weight (N in previous slide)} )</td>
</tr>
<tr>
<td>PAU Readmissions Adjustment $</td>
<td>( J = I \times C )</td>
</tr>
<tr>
<td>PAU Readmissions Adjustment $(Normalized)</td>
<td>( K = \frac{J \times \text{(Adjusted proposed required revenue reduction) \times \text{Readmissions Domain Weight (N in previous slide)}}}{\text{Statewide Total J}} )</td>
</tr>
<tr>
<td>PAU reduction $</td>
<td>( L = G + K )</td>
</tr>
<tr>
<td>PAU reduction %</td>
<td>( M = L \div C )</td>
</tr>
</tbody>
</table>

*Note: Adjusted proposed required revenue reduction and domain weight values should be calculated and included in the formulas.*
RY 2024 PAU Revenue Adjustments

Total Penalties: -$95,969,711

% Permanent Revenue: -0.49%
RY 2025 Maximum Guardrail under Maryland Hospital Performance-Based Programs
Final Recommendations for RY 2025

- Percent of *Maryland Medicare revenue at-risk for quality (6%)* multiplied by the percent of *Maryland revenue attributable to inpatient services*

- RY 2025 Guardrail: 6% x 58%* = 3.48%

- The quality adjustments are applied to inpatient revenue centers, similar to the approach used by CMS.

- RRIP-Disparity Gap is not included to encourage focus on and express the importance of advancing health equity

<table>
<thead>
<tr>
<th>RY 2025 Quality Program Revenue Adjustments</th>
<th>Max Penalty</th>
<th>Max Reward</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHAC</td>
<td>-2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>RRIP</td>
<td>-2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>QBR</td>
<td>-2.0%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

*CY2022 % IP Services
Digital Measures Reporting Requirements

Detailed reporting and submission information may be found on the CRISP website.
# Digital Measures Reporting: Measures

<table>
<thead>
<tr>
<th>Reporting Period/ Payment Determination</th>
<th>CMS Measures</th>
<th>Maryland Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2022/ FY 2024</td>
<td>Three self-selected eCQMs plus Safe Use Opioids</td>
<td>Four eCQMs: Two self-selected eCQMs Two required measures: Safe Opioids ED-2</td>
</tr>
<tr>
<td>CY 2023/ FY 2025</td>
<td>Three self-selected eCQMs plus Safe Use Opioids Concurrent Prescribing</td>
<td>Six required eCQMs: Safe Opioids ED-2 hyperglycemia hypoglycemia Cesarean Birth Severe Obstetric complications Clinical data elements for two hybrid measures (beginning July 2023) 30-day mortality 30-day readmissions</td>
</tr>
<tr>
<td></td>
<td>Clinical data elements for two hybrid measures (beginning July 2023) 30-day mortality 30-day readmissions</td>
<td></td>
</tr>
</tbody>
</table>
# Digital Measures Reporting: Timeline

## Data Submission Due Dates

### CY 2023 Performance Period Submission Windows for eCQMs

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Open Date</th>
<th>Close Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1- 2023 data</td>
<td>07/15/2023</td>
<td>10/02/2023</td>
</tr>
<tr>
<td>Q2- 2023 data</td>
<td>07/15/2023</td>
<td>10/02/2023</td>
</tr>
<tr>
<td>Q3- 2023 data</td>
<td>10/15/2023</td>
<td>12/30/2023</td>
</tr>
<tr>
<td>Q4 2023 data</td>
<td>01/15/2024</td>
<td>04/01/2024</td>
</tr>
</tbody>
</table>

### CY 2023 Performance Period Submission Windows for Hybrid Clinical Data Elements

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Open Date</th>
<th>Close Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 2023 data</td>
<td>01/15/2024</td>
<td>04/01/2024</td>
</tr>
<tr>
<td>Q4 2023 data</td>
<td>01/15/2024</td>
<td>04/01/2024</td>
</tr>
</tbody>
</table>
CY 2023 Monitoring Reports
Monitoring Measures Update

- 30-Day All-Cause Mortality - death occurs up to 30 days post hospital discharge
- Excess Days in Acute Care (EDAC) - excess days that a hospital’s patients spent in acute care within 30 days after discharge (ED visits, Obs stays, unplanned readmissions)
- Medicare TFU disparity gap measure - applying PAI to Medicare TFU measure
- Develop Timely Follow Up after a Behavioral Health Encounter measure
- Emergency Department Dramatic Improvement Effort (EDDIE)
Inpatient Diabetes Screening Measure Definition

- **Numerator:** # of inpatients with a CRISP A1c record with admit date <= service date <= discharge date
- **Denominator:** # of inpatient discharges patient in monitoring period
- **Exclusions**
  - <35 years old
  - Died in hospital
  - Transferred
  - AMA
Inpatient Diabetes Screening Policy Update

- Policy is currently in monitoring status
- Staff will evaluate transition to payment policy at end of CY23
- CRISP and HSCRC evaluated use of hospital lab feeds to track increases in IP A1c screening
- Hospital-level reporting now available in CRISP portal
- Working w/ CRISP on patient-level reporting
- Hospitals should confirm accuracy of A1c reporting in LOINC feeds to CRISP
Avoidable ED Utilization Measure Update

- Measure focuses on reducing utilization by multi-visit patients
- Currently in monitoring status
- Staff will evaluate transition to payment policy at end of CY23
- Numerator: # of ED visits at a given hospital by patients who have >= 4 visits at any hospital in calendar year
- Denominator: # of ED visits at a given hospital
- Hospital-level reporting currently available on CRISP portal
- Staff working w/ CRISP on patient-level report
<table>
<thead>
<tr>
<th>hospid</th>
<th>name</th>
<th>Visit Count, All ED Patients, 12 months ending 03/31/2023</th>
<th>Visit Count, MVPs, 12 months ending 03/31/2023</th>
<th>% Visits by MVPs, 12 months ending 03/31/2023</th>
<th>Percent Change from Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>210000</td>
<td>Statewide</td>
<td>2054629</td>
<td>524714</td>
<td>25.54</td>
<td>0.63</td>
</tr>
<tr>
<td>210001</td>
<td>Meritus</td>
<td>66178</td>
<td>16967</td>
<td>25.64</td>
<td>1.75</td>
</tr>
<tr>
<td>210002</td>
<td>UMMC</td>
<td>50574</td>
<td>22137</td>
<td>43.77</td>
<td>0.9</td>
</tr>
<tr>
<td>210003</td>
<td>UM-Capital Region Medical Center</td>
<td>37497</td>
<td>6798</td>
<td>18.13</td>
<td>-1.15</td>
</tr>
<tr>
<td>210004</td>
<td>Holy Cross</td>
<td>64260</td>
<td>11309</td>
<td>17.6</td>
<td>3.53</td>
</tr>
<tr>
<td>210005</td>
<td>Frederick</td>
<td>70242</td>
<td>13938</td>
<td>19.84</td>
<td>1.54</td>
</tr>
<tr>
<td>210006</td>
<td>UM-Harford</td>
<td>20435</td>
<td>5675</td>
<td>27.77</td>
<td>1.83</td>
</tr>
<tr>
<td>210008</td>
<td>Mercy</td>
<td>37646</td>
<td>14732</td>
<td>39.13</td>
<td>-1.61</td>
</tr>
<tr>
<td>210009</td>
<td>Johns Hopkins</td>
<td>89502</td>
<td>32898</td>
<td>36.76</td>
<td>0.49</td>
</tr>
<tr>
<td>210010</td>
<td>UM-Dorchester</td>
<td>14265</td>
<td>4245</td>
<td>29.76</td>
<td>2.09</td>
</tr>
</tbody>
</table>
EDDIE (Emergency Department Dramatic Improvement Effort)

- Monthly, public reporting of three measures:
  - ED1 Inpatient arrival to admission time
  - OP18 Outpatient ED arrival to discharge time
  - EMS turnaround time (data from MIEMSS)

- Hospital reporting:
  - Monthly reporting of ED1 and OP18 starting in July or August
  - Data will be used for public reporting at Commission meetings and other venues
  - HSCRC staff have been told this is feasible since most hospitals already monitor wait time data
  - Hospitals who do not report on monthly basis will be listed in public report
  - HSCRC will provide excel reporting template with high level specifications

**Rationale:**
Commission is prioritizing immediate reporting of ED wait time data for public reporting, while developing payment incentives for CY 2024. Monthly, publicly reported timely ED wait time should drive improvement.
HSCRC RY25 Policy Review-CRISP

June 2023
CRISP Reporting Services (CRS) Introduction
CRISP Reporting Services

- CRS (reports.crisphealth.org) hosts reports for the HSCRC Quality Programs.
- HSCRC Regulatory reports and SIHIS Directional Indicators are refreshed once per month (beginning and middle of the month, respectively)
You can access CRS at reports.crisphealth.org with your User ID, password, and accepting the Authy two factor authentication notification.

If you do not have access to CRS, please reach out to support@crisphealth.org or the CRS Point of Contact for your organization.

Questions or Concerns? Please contact the CRISP Customer Care Team at support@crisphealth.org or 877-962-7477.
Reports favored by users appear here.

‘Report Updates’ provides details about the most recent release.

Users can search for reports in the search bar.

Access User Guides for each report by clicking this icon.

By clicking the card, you will be taken to another page that displays the reports available to the users.
Users can download all the Static HSCRC Regulatory Reports at once. By clicking on the Download HSCRC Regulatory Reports button, the Generate HSCRC Regulatory Reports pop-out window will appear. Users can select multiple hospitals. To download the most recent reports, click the Only New Reports check box.
The wrench and spanner icon allows users to reorder the reports.

Users can click the heart to favorite the report.

Users can view archived reports by clicking the clock icon.

A legend of the icons appears at the bottom of the page.
Quality Financial Impact Dashboard (QFID)
Purpose of the Dashboard:
- To give executive leadership high-level insight on their year-to-date performance in the quality pay-for-performance programs as it relates to the overall budget in the Global Budget Revenue (GBR) model.
Report Features

The hospital filter at the top of the screen allows users to select which hospital(s) they want to view in the dashboard. Please select “Apply” after selecting the hospitals.

The green to red bar shows users how close or far they are from the reward/penalty cutpoint.

Red indicates performance that would receive a penalty

Blue (if applicable) represents a revenue-neutral “hold harmless zone”

Green represents performance receiving a reward
QFID Report Features

The comparison year on the left half of the screen allows users to change what year they are comparing against the current year. Please note that comparison years will use the current year’s rate logic.

The “Month YTD” filter allows users to change which data load they are using as the current performance period.

The Excel and Print features allow the users to export the report they are viewing.
The revenue adjustments in this dashboard are estimates, based on a hospital’s last approved global budget
  • These revenue adjustment estimates will be updated to exact totals for the current rate-year through the update factor process at the end of the fiscal year
  • The revenue percentages are also provided, and hospitals are welcome to apply these percentages against their current global budget projections

Hospital rankings are calculated by sorting on “% Reward/Penalty” from highest percent reward

Current performance and financial impact are calculated to reflect the performance to-date and resultant financial impact, and will be updated throughout the year as new data become available

RY25 methodology will be updated in the report on July 14th, 2023
QFID has five tabs: one for the total financial impact and one for each of the four quality programs with each program's current performance year financial impact and salient performance metrics. To view a page, the user must click on the box for the tab they want to view.
The Total page allows users to view the current and comparison years along with the % change for each of the quality programs and the total quality revenue adjustment.
Summary View MHAC (Maryland Hospital Acquired Conditions) Tab

The multi hospital view shows the MHAC score, estimated reward/penalty in percent and dollars as well as the hospital rank for the selected hospital(s). The same measures are available for the comparison year.
MHAC tab includes: MHAC score, estimated percent reward/penalty, estimated financial reward/penalty, hospital rank for MHAC, and tables for the observed versus expected PPC.

First table shows the PPCs the hospital is being held accountable. The blue bar is the observed PPC occurrence; the orange line is the expected.

The second PPC tables the actual values for each PPC and the OE ratio. Red means the observed is higher than expected and green means the observed is lower than expected.
Clicking the “MHAC Summary Report” button at the top right on either the summary or details page will launch the full selection of reports supporting the MHAC Program.
Avoidable Admissions Report
The Avoidable Admissions Report allows users to see per capita Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) values.

The report displays PQIs and PDIs that are assigned to hospitals based on geographic attribution.

The following tabs are available:
- Savings Performance
- Summary by PQI
- Summary by PDI
- PQIs by Zip
<table>
<thead>
<tr>
<th>Filter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Year in which the PQI occurred.</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Hospital to which the PQIs are attributed. This is not necessarily the hospital where the visit occurred.</td>
</tr>
<tr>
<td>Payer</td>
<td>Primary expected payer as listed in case mix data</td>
</tr>
<tr>
<td>Gender</td>
<td>Patient Gender</td>
</tr>
<tr>
<td>Age Group</td>
<td>Patient Age, distributed into available ACS census age groups.</td>
</tr>
</tbody>
</table>
### Avoidable Admissions Report

#### Adults Summary by PQI

<table>
<thead>
<tr>
<th>Statewide</th>
<th>Overall Composite</th>
<th>Overall Composite per 1000</th>
<th>Diabetes Composite</th>
<th>Diabetes Composite per 1000</th>
<th>Acute Composite</th>
<th>Acute Composite per 1000</th>
<th>COPD</th>
<th>COPD/ Asthma per 1000</th>
<th>Hypertension</th>
<th>Hypertension per 1000</th>
<th>Congestive Heart Failure</th>
<th>Congestive Heart Failure per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Selected Hospitals Subtotal

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>% Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Multiple Values)</td>
<td></td>
</tr>
</tbody>
</table>

### PQI notes:
- PQI rates do not include risk adjustment methodology.
- AHRQ PQI version 2021.
- Data is annualized so that calendar year to date data is presented as of that rate continued for the rest of the year. Data is refreshed monthly.
- Census-based population data is refreshed as it becomes publicly available.
- MPA VB (In) 20214 attribution is used for the MPA portion of the algorithm. See user guide for further explanation.

#### Cesarean Data Available Through

4/30/2022
Readmissions Summary
Readmissions Summary Overview

• The report allows users to filter and drill down their hospital’s readmission data.

• The following tabs are available
  • Landing Page
  • Improvement
  • Attainment
  • Trends & Locations
  • Unadjusted Hospital Readmission Trends
  • Case-mix Adjusted Readmission Trends
  • Service Line Readmission Analysis
  • Length of Discharge to Readmission (Requires PHI access)
  • Forecasting
  • Patient Level Details (Requires PHI access)
  • Documentation
  • Summary by Month
Readmissions Summary
## Filters

<table>
<thead>
<tr>
<th>Filter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Period Structure</td>
<td>View either the complete base period (Based on CY2018 data) and/or matched YTD performance period.</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Select the year(s) of discharge.</td>
</tr>
<tr>
<td>Hospital Name</td>
<td>Filter on one or more hospitals.</td>
</tr>
<tr>
<td>Index APR Service Line</td>
<td>Filter groups services into higher level categories, which is based on the index hospital.</td>
</tr>
<tr>
<td>Index APR Value</td>
<td>APR value from the index hospital.</td>
</tr>
</tbody>
</table>
| Need Type                   | **High Utilizer:** 3+ bedded care visits (inpatient and observation stays over 24 hours) in the 12 months prior to their index visit  
**Rising Needs:** 2+ visits bedded care or ED in the 12 months before their index visit |
| Payer                       | Filter based on the type of payer (commercial, Medicare, Medicaid, and charity/self-pay) |
| Primary Diagnosis           | Diagnosis at index visit                                                   |
| Race                        | Race reported by hospital at visit                                          |
Readmissions Summary

- Refresh – Used to refresh data for complex queries
- Revert – restores page to default view
- Pause – prevents the report from loading for each filter sections. Extremely useful if making multiple sections during a session.

- Print – export view into a PDF
Statewide Integrated Health Improvement Strategy (SIHIS) Overview
Statewide Integrated Health Improvement Strategy (SIHIS)

• SIHIS is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.

• CMMI approved the SIHIS goals in March 2021.

• More information on SIHIS can be found on the HSCRC website. https://hscrc.maryland.gov/Pages/Statewide-Integrated-Health-Improvement-Strategy-.aspx
Statewide Goals Across Three Domains

1. Hospital Quality
   - Reduce avoidable admissions
   - Improve Readmission Rates by Reducing Within-Hospital Disparities

2. Care Transformation Across the System
   - Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
   - Improve care coordination for patients with chronic conditions

3. Total Population Health
   - Priority Area 1 (Diabetes): Reduce the mean BMI for adult Maryland residents
   - Priority Area 2 (Opioids): Improve overdose mortality
   - Priority Area 3 (Maternal and Child Health):
     - Reduce severe maternal morbidity rate
     - Decrease asthma-related emergency department visit rates for ages 2-17
Many of the data sources used for official SIHIS monitoring are calculated annually on delayed data sources.

CRISP partnered with HSCRC and MDH to identify proxy measures that would enable reporting in a timely fashion. The reporting suite is referred to as “directional indicators”

The reports include either proxy or actual measures for all the SIHIS goals.

The reporting suite has separate modules for each of the domains: Hospital Quality; Care Transformation across the System; and Population Health.

The SIHIS Directional Indicators Dashboard is updated in the middle of the month.
Introduction
• Measure aims to capture the number of hospitals that reduce readmission disparities by 50% or more by 2026.
• Readmission rates by hospital are examined according to levels of patient adversity as measured by the Patient Adversity Index (PAI).

Reported Measure
• Reported in Casemix data
• Success in the measure is defined as at least 50% of hospitals having achieved at least a 50%

Key Findings
• Presents the big picture findings
  • 6 Maryland hospitals are on track to meet the target by 2026
• There is a lag in the data presented
  • Data available through date in top right corner of chart

Readmissions Disparity Gap Comparison Charts
• Able to view and filter by hospital to see which hospitals are on track and how each hospitals trends by the categories of PAI.
Support and Training

• To request access or support with credentialing, contact support@crisphealth.org
• For questions about the reports within CRS or suggestions for report enhancements contact report-support@crisphealth.org
• Detailed User Guides are available for all reports on the CRS website
• Webinars on select reports are on the CRISP Learning System website (crisphealth.org/learning-system/crs)
Accessing Reports

- Email your Organization’s CRS Point of Contact (POC) to request access to portal:
  - Request should specify hospital and level of access (summary vs. case-level)
  - Access will be granted to all hospital reports (i.e., not program specific)
- CRS Point of Contact (CFO or designee) confirm and approve access requests for each organization
- Questions regarding **content** of static reports or report **policy** should be directed to the HSCRC quality email ([hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov))
- Questions regarding **access** issues or **tableau** reports should be directed to CRISP Support email ([support@crisphealth.org](mailto:support@crisphealth.org))
Non-HSCRC Quality Resources

- Why Not the Best?
- CMS Care Compare
- MHCC Health Care Quality Reports
- QualityNet
- LeapFrog Hospital Safety Grades
- US News & World Report - Hospital Rankings
- Commonwealth Fund Report
Acknowledgments

Thanks to the Performance Measurement Work Group members, MHA, CRISP, the hospital industry, consumers, and other stakeholders for their work on developing and vetting Maryland’s performance-based payment methodologies.
Q & A

• Please type your Question into the Questions Bar

• Additional or unanswered questions can be emailed to the HSCRC Quality mailbox: hscrc.quality@maryland.gov

• Thank you again for your participation!